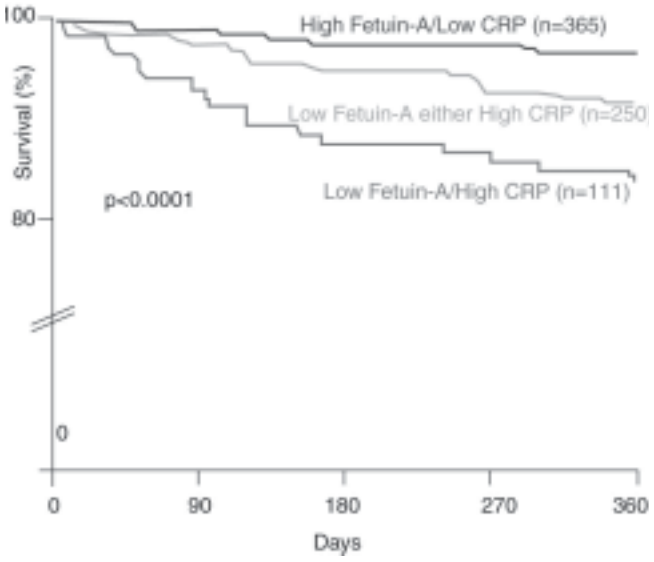
high CRP level (tertile 3). Results: Plasma fetuin-A and CRP concentrations at admission averaged 95±27mg/L and 11±16UI, respectively with low fetuin-A defined as <69mg/L and high CRP level as 25UI. At one year follow up (n=726, 97%), cardiovascular mortality (n=50, 7%) was 16% (18/111), 9% (21/250) and 3% (11/365) in patients with low fetuin-A/high CRP (n=111), either low fetuin or high CRP (n=250) and high fetuin-A/low CRP (n=365), respectively. By multivaritate analysis low fetuin-A/high CRP level remained independently predictive of outcome (OR=3.4 [1.6-7.3], p=0.001, Figure 1) after adjustment to ST elevation, GRACE score and medical treatment. In contrast, CRP and fetuin-A alone failed to predict outcome.

Conclusions: Inflammatory imbalance assessed by combining fetuin-A and CRP values is an important predictor of cardiovascular death in ACS patients.



014

Impact of type of pre-admission sulfonylureas on mortality and cardiovascular outcomes in diabetic patients with acute myocardial infarction

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Background: the impact of antidiabetic medications on clinical outcomes in patients developing acute myocardial infarction (MI) is controversial. We sought to determine whether in-hospital outcomes in patients who were on sulfonylureas (SUs) when they developed their MIs differed from those of diabetic patients not receiving SUs, and whether clinical outcomes were related to the pancreatic cell specificity of SUs.

Methods and Results: we analyzed the outcomes of the 1310 diabetic patients included in the nationwide French registry of Acute ST-elevation and non ST-elevation myocardial infarction (FAST-MI) in 2005. Medications used before the acute episode were recorded. In-hospital complications were analyzed according to prior antidiabetic treatment. Mortality was lower in patients previously treated with SUs (3.9%), versus those on other oral medications (6.4%), insulin (9.4%) or no medication (8.4%) (p=0.014). Among SU-treated patients, in-hospital mortality was lower in patients receiving pancreatic cell-specific SUs (gliclazide or glimepiride)(2.7%), compared with those on glibenclamide (7.5%) (p=0.019). Arrhythmias and ischemic complications were also less frequent in patients receiving gliclazide/glimepiride. The lower risk in patients receiving gliclazide/glimepiride versus glibenclamide persisted after multivariate adjustment (OR=0.15; 95%CI: 0.04-0.56) and in propensity score-matched cohorts.

Conclusion: In this nationwide registry of patients hospitalized for acute MI, no hazard was associated with the use of SUs before the acute episode. In addition, patients who had previously received gliclazide/glimepiride had better in-hospital outcomes, compared to those on glibenclamide.

015

Impact of discharge heart rate on 30 day mortality in patients with acute myocardial infarction

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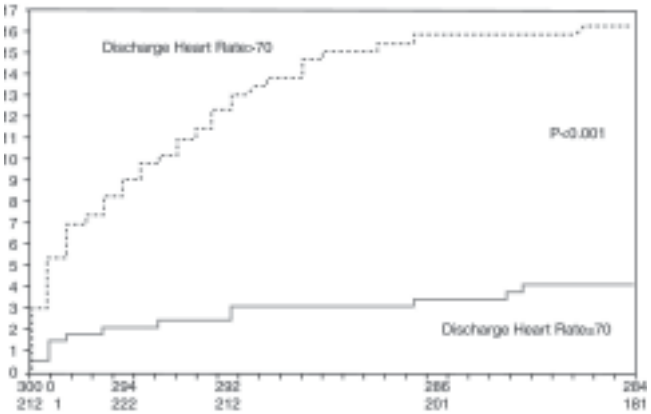
Background: In patients with acute myocardial infarction (MI), beta-blockers are recommended and contribute to control the heart rate (HR). The factors associated with HR and outcome of patients discharged with HR>70 beats per minute (bpm) is poorly documented.

Methods: Prospective registry including patients with acute MI. Recorded variables corresponded to the CARDS dataset. The proportion of patients discharged with HR>70 bpm was assessed. Multivariate regression was used to determine factors associated with HR at discharge and logistic regression was used to determine the prognostic value of high HR at discharge on 30 day mortality.

Results: Among the 837 patients, 592 survived and were discharged with a beta blocker. Discharge HR was ≤ 70 bpm in 61% when a betablocker was given and in 31% without beta blocker (p<0.001). Discharge HR was associated with older age, admission HR, admission systolic blood pressure, BNP level, diabetes, use of beta blockers and ACEI. Patients discharged with HR>70 bpm (n=227, 39%) had a threefold higher mortality as compared with those with HR≤ 70 (figure). Multivariate analysis showed that a HR≥70 at discharge was an independent predictor of 30 day mortality on top of the GRACE risk score and use of beta blockers.

Conclusions: Among patients discharged after acute MI, those with HR>70 have higher 30 day mortality, independently of the GRACE risk score and use of beta blockers.



Mortality by discharge heart rate